



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	<b>Specialty/facility name (if applicable):</b>

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

**Q1. Is the medication being prescribed by or in consultation with one of the following?**

- |  |   |
|--|---|
| <input type="checkbox"/> Rheumatologist (Rheumatoid Arthritis (RA), Polymyalgia rheumatica (PMR), Polyarticular juvenile idiopathic arthritis (pJIA), Giant Cell Arteritis (GCA) | <input type="checkbox"/> Oncologist, Hematologist, or Rheumatologist (immune checkpoint inhibitor-related toxicity) |
|--|---|

**Q2. Is the request for continuation of therapy? If YES, go to 19. If NO, go to 3.**

- Yes  No

**Q3. Is the member 18 years of age or older with moderately to severely active RA? If YES, go to 4. If NO, go to 10.**

- Yes  No

**Q4. Has the member previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Xeljanz) for RA? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. If YES, go to 29. If NO, go to 5.**



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
----------------------	-------------------------

Yes

No

Q5. Has the member tested positive for either of the following biomarkers? Attach laboratory results, chart notes, or medical record documentation of biomarker testing. If YES, go to 7. If NO, go to 6.

Rheumatoid factor (RF)

Anti-cyclic citrullinated peptide (anti-CCP)

Q6. Has the member been tested for all of the following? Attach laboratory results, chart notes, or medical record documentation of biomarker testing.

RF

Anti-CCP

CRP and/or ESR

Q7. The member has failed to achieve a low disease activity after a 3-month trial of methotrexate (MTX) monotherapy at a maximum titrated dose of at least 15 mg per week and meets any of the following conditions. If YES, go to 31. If NO, go to 8.

Member has had a documented inadequate response to MTX in combination with or at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s).

Member has experienced a documented intolerable adverse event to hydroxychloroquine or sulfasalazine.

Member has a documented contraindication to hydroxychloroquine (see Appendix) and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).

Member has moderate to high disease activity.

Q8. The member was unable to tolerate a 3-month trial of MTX monotherapy at a maximum titrated dose of at least 15 mg per week and meets any of the following conditions. If YES, go to 31. If NO, go to 9.

Member has had a documented inadequate response to MTX in combination with at least one other conventional synthetic drug (i.e., hydroxychloroquine and/or sulfasalazine) after a 3-month trial at a maximum tolerated dose(s).

Member has stopped taking MTX and has had a documented inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s).



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

Patient Name:

Prescriber Name:

- Member has experienced a documented intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine.
- Member has a documented contraindication to leflunomide, hydroxychloroquine (see Appendix), and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).
- Member has moderate to high disease activity.

Q9. The member has experienced a documented intolerable adverse event or has a documented contraindication to MTX (see Appendix), discontinues MTX, and meets any of the following conditions. If YES, go to 31.

- Member has had a documented inadequate response to another conventional synthetic drug (i.e., leflunomide, hydroxychloroquine, and/or sulfasalazine) alone or in combination after a 3-month trial at a maximum tolerated dose(s).
- Member has experienced a documented intolerable adverse event to leflunomide, hydroxychloroquine, or sulfasalazine.
- Member has a documented contraindication to leflunomide, hydroxychloroquine (see Appendix), and sulfasalazine (e.g., porphyria, intestinal or urinary obstruction).
- Member has moderate to high disease activity.

Q10. Is the member 18 years of age or older with PMR? If YES, go to 11. If NO, go to 12.

- Yes  No

Q11. Has the member experienced any of the following? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. If YES, go to 31.

- Inadequate response to systemic corticosteroids
- Disease flare during corticosteroid taper
- Inadequate response to methotrexate
- Intolerance or contraindication to both corticosteroids and methotrexate

Q12. Does the patient have a diagnosis of pJIA and weigh greater than or equal to 64 kg? If YES, go to 13. If NO, go to 17.



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Has the member previously received a biologic or targeted synthetic drug (e.g., Xeljanz) for active pJIA? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If YES, go to 31. If NO, go to 14.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Has the member had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If YES, go to 31. If NO go to 15.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Has the member had an inadequate response to a trial of scheduled NSAIDs and/or intra-articular glucocorticoids and one of the following risk factors for poor outcome? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If YES, go to 31. If NO, go to 16.	
<input type="checkbox"/> Involvement of ankle, wrist, hip, SI joint, or TMJ	
<input type="checkbox"/> Erosive disease or enthesitis	
<input type="checkbox"/> Delay in diagnosis	
<input type="checkbox"/> Elevated inflammatory markers	
<input type="checkbox"/> Symmetric disease	
Q16. Does the member have risk factors for disease severity and potentially a more refractory disease course and the member also meets one of the following. If YES, go to 31.	
<input type="checkbox"/> High-risk joints involved (e.g., cervical spine, wrist, hip)	
<input type="checkbox"/> High disease activity	
<input type="checkbox"/> High risk for disabling joint disease	



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q17. Does the member have moderate or severe immunotherapy-related inflammatory arthritis (immune checkpoint inhibitor-related toxicity)? If YES, go to 18. If NO, go to 20. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q18. Has the member had an inadequate response to corticosteroids OR a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. If YES, go to 31. If NO, go to 19. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q19. Has the member had an intolerance or contraindication to both corticosteroids AND a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? Attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy. If YES, go to 31. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q20. Does the patient have a diagnosis of GCA that has been confirmed by one of the following. If YES, go to 31. <input type="checkbox"/> Temporal artery biopsy or cross-sectional imaging <input type="checkbox"/> Elevated ESR and/or CRP	
Q21. Is the member continuing therapy for moderately to severely active RA? If YES, go to 22. If NO, go to 23. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q22. Has the member achieved or maintained a positive clinical response (20% improvement in tender/swollen joint count, pain, or disability)? Attach chart notes or medical record documentation supporting positive clinical response. If YES, go to 29. <input type="checkbox"/> Yes <input type="checkbox"/> No	



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Q23. Is the member continuing therapy for PMR? If YES, go to 24. If NO, go to 25. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q24. Has the member shown improvement in any of the following from baseline? Attach chart notes or medical record documentation supporting positive clinical response. If YES, go to 31. <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Hip or shoulder pain <input type="checkbox"/> Hip or shoulder range of motion <input type="checkbox"/> CRP and/or ESR	
Q25. Is the member continuing therapy for active pJIA and weighs 63 kg? If YES, go to 26. If NO, go to 27. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q26. Has the member shown improvement in any of the following from baseline? Attach chart notes or medical record documentation supporting positive clinical response. If YES, go to 31. <input type="checkbox"/> Number of joints with active arthritis <input type="checkbox"/> Number of joints with limited movement <input type="checkbox"/> Functional ability	
Q27. Is the member continuing therapy for immunotherapy-related inflammatory arthritis? If YES, go to 28. If NO, go to 29. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q28. Has the member achieved or maintained low disease activity or symptom improvement? Attach chart notes or medical record documentation supporting positive clinical response. If YES, go to 31. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q29. Is the member continuing therapy for GCA?	



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q30. Has the member shown improvement in any of the following from baseline? Attach chart notes or medical record documentation supporting positive clinical response.	
<input type="checkbox"/> Headaches	
<input type="checkbox"/> Scalp tenderness	
<input type="checkbox"/> Temporal artery tenderness/thickening	
<input type="checkbox"/> Constitutional symptoms (e.g., weight loss, fever, fatigue)	
<input type="checkbox"/> Jaw/tongue claudication	
<input type="checkbox"/> Visual symptoms (e.g., amaurosis fugax, visual loss, diplopia)	
<input type="checkbox"/> PMR symptoms (e.g., shoulder/hip girdle pain)	
<input type="checkbox"/> Limb claudication	
Q31. Has the member had a documented negative TB test (TST or IGRA) within 6 months of starting therapy? If YES, go to 34. If NO, go to 32.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q32. If TB test was positive, has active TB been ruled out (e.g., chest x-ray)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q33. If latent TB is present, has treatment been initiated before starting the requested medication?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q34. Is the member using the requested medication concurrently with another biologic or targeted synthetic drug?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q35. Additional Information:	



**PRIOR AUTHORIZATION REQUEST FORM**  
Individual and Family Plans

**Kevzara**

**Fax back to: (833) 605-4407**

Phone: (215) 991-4300

---

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>
----------------------	-------------------------

---

Prescriber Signature

---

Date

v2026